Group Vision Care Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

STATE OF VERMONT

MAIL THIS FORM TO: CIGNA HealthCare Service Center
P.O. Box 5200
Scranton, PA 18505-5200

TELEPHONE: 1.800.351.8513

EMPLOYEE'S INSTRUCTIONS FOR FILING A VISION CARE CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

USE A SEPARATE FORM FOR **EACH** MEMBER OF THE FAMILY FOR **EACH** SEPARATE CLAIM.

- COMPLETE EVERY ENTRY ON THIS FORM IN THE SECTION ENTITLED "TO BE COMPLETED BY EMPLOYEE".
- CLAIM WILL BE DELAYED IF SOCIAL SECURITY NUMBER IS NOT COMPLETED.
- HAVE YOUR DOCTOR COMPLETE THE SECTION ENTITLED "TO BE COMPLETED BY THE DOCTOR".
- ASK OTHER PROVIDERS OF SERVICE TO GIVE YOU AN ITEMIZED BILL WHICH INCLUDES:
  - Patient's Name - Type of Service - Date of Service - Charge for Each Service or Supply.
- SAVE YOUR BILLS until you have received all bills for that sickness or accident.
- Send this form and your bills to address shown at the top of this form.
- INDICATE YOUR EMPLOYER'S NAME ON ALL CORRESPONDENCE.

TO BE COMPLETED BY THE EMPLOYEE

A. EMPLOYER

ACCOUNT NUMBER **3145640**

B. PLANT LOCATION/DIVISION

☐ Hourly ☐ Salaried

DATE HIRED

C. EMPLOYEE NAME

DATE OF BIRTH

D. EMPLOYEE'S SOC. SEC. NO.

E. ADDRESS *(Street, City, State, Zip)*

F. HAS COVERAGE EVER BEEN TERMINATED? ☐ Yes ☐ No

IF YES, GIVE REASON AND DATE OF TERMINATION

G. NAME OF SPOUSE

SPOUSE'S DATE OF BIRTH

H. SPOUSE'S SOC. SEC. NO.

I. SPOUSE EMPLOYED - IF NO, HAS SPOUSE BEEN EMPLOYED ☐ Yes ☐ No | DURING LAST 12 MONTHS ☐ Yes ☐ No

J. NAME AND ADDRESS OF SPOUSE'S EMPLOYER

K. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP OR GOVERNMENT PLAN SUCH AS MEDICARE, OR UNDER AUTOMOBILE MANDATORY NO-FAULT COVERAGE, WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? ☐ Yes ☐ No IF YES, GIVE NAME OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS.

NAME | ADDRESS | POLICY NUMBER

L. IS THIS ACCIDENT OR SICKNESS DUE TO EMPLOYMENT? ☐ Yes ☐ No

M. CLAIM IS MADE FOR ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME OF PATIENT *First* *Last*

DATE OF BIRTH

IF FULL TIME STUDENT *School* *City*

N. WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? ☐ Yes ☐ No

WAS INJURY CAUSED BY YOUR WORK? ☐ Yes ☐ No

HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS' COMPENSATION CARRIER? ☐ Yes ☐ No

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or organization to release any information necessary to process this claim to the Plan Administrator or its authorized agent. I understand that I or my authorized representative will receive a copy of the authorization upon request.

SIGN HERE → Patient or parent/guardian signature _____ Date _____

I hereby authorize payment directly to the undersigned doctor of the Vision Care benefits otherwise payable to me and to the supplying or dispensing optician for the ophthalmic materials and related charges according to the attached invoice.

Date _____ Signature of employee _____

TO BE COMPLETED BY THE DOCTOR

1. Has patient worn glasses before this examination? ☐ Yes ☐ No Type _____ Date of Prev. Exam. _____

2. If Yes, state reason for replacement _____

3. Does your examination indicate that glasses should be prescribed? ☐ Yes ☐ No Does Rx change more than .5 diopters or 10% in axis for astigmatism? ☐ Yes ☐ No

4. If you prescribe glasses, check type: ☐ Single Vision ☐ Bifocal ☐ Trifocal

   Other (Describe) _____

5. Did exam include refraction? ☐ Yes ☐ No

6. Has cataract surgery been performed? ☐ Yes ☐ No Date _____

7. Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? ☐ Yes ☐ No

	CPT4 Code	Dates of Service	Charges $
8. EXAMINATIONS			
A. Vision Survey			
B. Complete Visual Analysis (With Tonometry)			
C. Complete Visual Analysis (Without Tonometry)			
9. MATERIALS & PROFESSIONAL SERVICES			
A. Single Vision Lenses			
B. Bifocal Lenses			
C. Trifocal Lenses			
D. Lenticular Lenses			
E. Contact Lenses, for Each Lens			
F. Frame			
G. Oversize			
H. Sunglasses			
I. Tint No.			
J. Photosensitive or Anti-reflective (Extra Charge)			
		TOTAL	

Date Service Began _____ Date Service Completed _____

Doctor's Name _____

Doctor's Address _____

I hereby certify that examinations have been completed and materials and services rendered as stated in this Part.

Doctor's Signature _____

SS# or Tax ID# _____

Date _____